Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Nueva Vida Behavioral Health and Associates

Respondent Name
American Home Assurance Co

MFDR Tracking Number
M4-14-1075-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
December 11, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…we are the referring HCP and we are billing for case management service…"

Amount in Dispute: $28.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Nueva Vida is not the treating doctor, and this is noted on the Explanation of Bill Review as "This service/supply is not covered according to the state fee schedule guideline."

Response Submitted by: AIG, 4100 Alpha Rd. Ste 700, Dallas, TX 75244

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 12, 2012	99361	$28.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the reimbursement guidelines for case management services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - This service/supply is not covered according to the state fee schedule fee schedule guideline.
   - This is a bundled or non covered procedure based on Medicare guidelines. No separate payment allowed.

Issues

1. Did the requestor submit required documentation as required by rule 134.204?

2. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied the disputed services as, "This service/supply is not covered according to the state fee schedule fee schedule guideline." 28 Texas Labor Code §134.204(e)(4) states in pertinent part, "Case management services require the treating doctor to submit documentation that identifies any HCP that contributes to the case management activity." Review of the submitted documentation finds the following;
    a. Case management note dated December 12, 2012 states, "General Purpose: Care Coordination" "Specific Purpose: Coordinating Care, Developing Treatment Plan" "Outcome: Continue medication management per Dr. Stephenson. Surgery has been denied times one to the lumbar spine as indicated by Dr. Siddiqui. This will be sent back for reconsideration."

    Review of the submitted documentation finds nothing to support the treating physician participated in the case management service. The carrier's position is supported.

2. The Division finds requirements of Rule §134(e)(4) are not met. Therefore, no payment can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		September 9, 2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.